Rivertown Acupuncture
60 Cedar Street
Dobbs Ferry, N.Y. 10502

Our Office Protects Your Health Information and Privacy

Dear Valued Patient,

This notice describes our office's policy for how medical information about you may be used and disclosed, how you can get access to this information, and how your privacy is being protected. In order to maintain the level of service that you expect from our office, we may need to share limited personal medical and financial information with your insurance company, with Worker's Compensation (and your employer as well in this instance), or with other medical practitioners that you authorize.

Safeguards in place at our office include:

- Limited access to facilities where information is stored.
- Policies and procedures for handling information.
- Requirements for third parties to contractually comply with privacy laws.
- All medical files and records (including email, regular mail, telephone, and faxes sent) are kept on permanent file.

Types of information that we gather and use:

In administering your health care, we gather and maintain information that may include non- public personal information:

- About your financial transactions with us (billing transactions).
- From your medical history, treatment notes, all test results, and any letters, faxes, emails or telephone conversations to or from other health care practitioners.
- From health care providers, insurance companies, workman's comp and your employer, and other third part administrators (*e.g*. requests for medical records, claim payment information).

We value our relationship, and respect your right to privacy. If you have questions about our privacy guidelines, please call at 914-674-4003 or email at rivertownacupuncure@yahoo.com.

Yours truly,

Randi Marie Hoffmann, Ac.
Rivertown Acupuncture

RIVERTOWN ACUPUNCTURE

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS
NAME ____
BIRTHDATE __________________

I understand that as part of my healthcare, or my legal dependent's healthcare, this organization originates and maintains health records describing health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care of treatment.
I understand that this information serves as:

- A basis for planning care and treatment.
- A means of communication among the many healthcare professionals who contribute to care.
- A source of information for applying diagnostic and medical information to a bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

I understand that I have the right:
- To object to the use of health information for directory purposes.
- To request restrictions as to how this health information may be used or disclosed to carry out treatment, payment or healthcare operations – and that the organization is not required to agree to the restrictions requested.
- To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereupon. I request the following restrictions to the use of disclosure of my health information:

Patient:
X____ __________
Patient Signature or Legal Representative **Date**

X____
Witness Signature